

UNITED STATES NUCLEAR REGULATORY COMMISSION REGION II 101 MARIETTA ST., N.W., SUITE 3100 ATLANTA, GEORGIA 30303

Report Nos. 50-259/79-48, 50-260/79-47 and 50-296/79-47

Licensee: Tennessee Valley Authority

500A Chestnut Street Tower II Chattanooga, Tennessee 37401

Facility: Browns Ferry Nuclear Plant

Docket Nos. 50-259, 50-260, and 50-296

License Nos. DPR-33, DPR-52, and DPR-68

Inspection at Browns Ferry Site near Athens, Alabama

Inspectors:

R. F. Sullivan

Date Signed

J. W. Chase

Approved by:

H. C. Dance, Section Chief, RONS Branch

3/20/80

Date Signed

3/20/80

Date Signed

Date Signed

SUMMARY

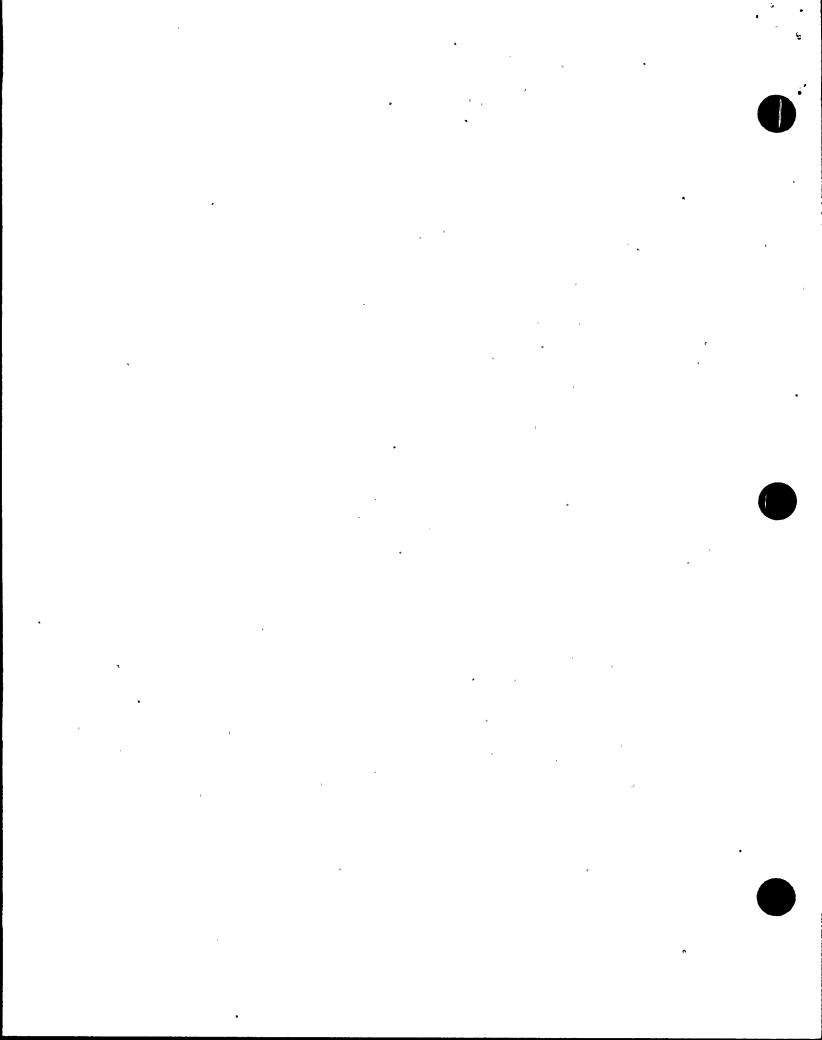
Inspection on December 10, 1979 through January 4, 1980

Areas Inspected

This routine inspection involved 65 resident inspector-hours in the areas of plant operations, plant tours, reportable occurrences, refueling, maintenance, surveillance testing, plant physical protection, and radiation area controls.

Results

Of the eight areas inspected no items of noncompliance or deviations were identified in seven areas. One item of apparent noncompliance was found in one area (Deficiency - use of test procedure which had been superceeded by revision, paragraph 7).



DETAILS

1. Persons Contacted

Licensee Employees

- H. L. Abercrombie, Plant Superintendent
- J. L. Harness, Assistant Plant Superintendent
- J. B. Studdard, Operations Supervisor
- R. Hunkapillar, Assistant Operations Supervisor
- J. A. Teague, Maintenance Supervisor, Electrical
- M. A. Haney, Maintenance Supervisor, Mechanical
- J. R. Pittman, Maintenance Supervisor, Instruments
- R. G. Metke, Results Section Supervisor
- G. T. Jones, Outage Director
- R. T. Smith, QA Supervisor
- J. D. Daniels, Boilermaker Foreman, Outage
- R. Mullins, Maintenance Specialist, Outage
- A. L. Burnett, Shift Engineer
- R. E. Jackson, Captain, Public Safety
- J. D. Glover, Shift Engineer
- R. R. Smallwood, Shift Engineer
- R. Cole, QA Site Representative Office of Power

Other licensee employees contacted included Licensed Senior Reactor Operators and Reactor Operators, auxiliary operators, craftsmen, technicians, public safety officers, QA personnel and engineering personnel.

2. Management Interviews

Management interviews were conducted on December 14, 21 and 27, 1979 and January 4, 1980 with the Plant Superintendent and selected members of his staff. The inspectors summarized the scope and findings of their inspection activities. The licensee was informed on the afternoon of December 21, 1979, that an apparent item of noncompliance had been identified earlier in the day relative to using an outdated procedure to leak test a Unit 2 equipment hatch.

3. Licensee Action on Previous Inspection Findings

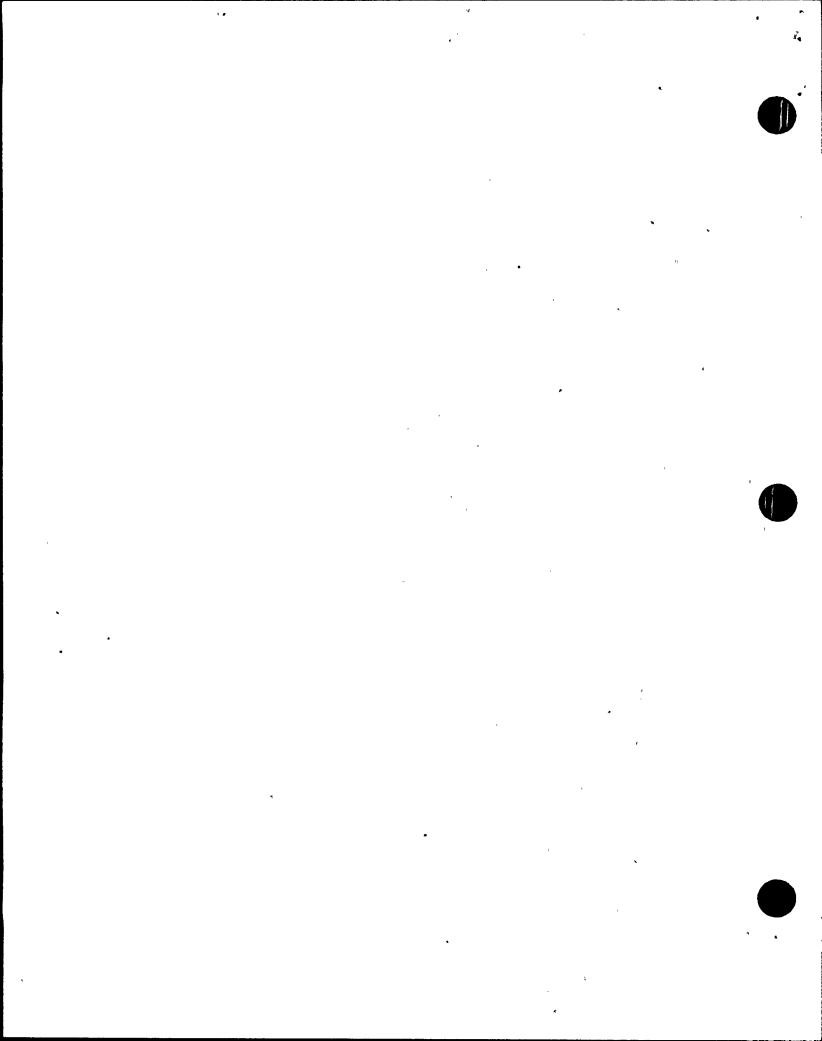
Not inspected.

4. Unresolved Items

No unresolved items were identified during this inspection.

5. Plant Operations

The inspectors kept informed on a daily basis of the overall plant status and any significant safety matters related to plant operations. Daily



discussions were held with plant management and various members of the plant operations staff. Frequent visits were made to the shift engineer's office and control rooms to review current reactor operating status and activities. Special visits were made to other plant locations to observe selected activities and to verify system or component status.

Selected portions of the daily journals and other operating records were reviewed on at least a weekly basis during the report period.

The inspectors made general plant tours on December 17, 19 and 27, 1979. Portions of the turbine building, each reactor building and outside areas were visited. Observations included witnessing work activities in progress, status and configuration of operating and standby safety systems, valve positions, snubber and hanger conditions, instrument readings and recordings, annunciator alarms, housekeeping, radiation area controls and vital area controls. Informal discussions were held with operators and other personnel about work activities and plant conditions.

No items of noncompliance or deviations were identified by the inspectors in the above areas.

6. Reportable Occurrence Review

The below listed licensee event reports were reviewed to determine if the information provided met NRC reporting requirements. The determination included adequacy of evert description and corrective action taken or planned, existence of potential generic problems and relative safety significance of each event.

LER No.	Date	<u>Event</u>
259/7834	12/19/79	Excessive leakage of main steam isolation valves.
259/792R1	11/23/79	SLC pump relief valve opened below setting.
259/7925	10/09/79	Main steam lines not isolated within T-5 time allowance.
259/7926	10/22/79	Recirculation pumps tripped by personnel error.
259/7931	12/12/79	Drywell air monitor inoperable.
259/7933	12/20/79	Reactor level sensor drift outside setpoint limit.
259/7934	12/21/79	Recirculation pump MG sets tripped due to personnel error.
260/797	05/29/79	Excessive leakage past main steal isolation valves.

. , **þ** • •

LER No.	' <u>Date</u> "	Event
260/7914	06/26/79	Local leak rate testing results R1 0730/79 exceeded limits.
260/7922	10/29/79	Rod Block Monitor inoperative due to personnel error.
260/7924	12/20/79	Pressure switch on main steam line setpoint low.
260/7925	01/04/80	Flow switch on main steam line had setpoint high.
296/7923	12/31/79	3C diesel generator tripped during test.

Corrective action indicated on the above reports was determined to be adequate. The inspectors questions were satisfactorily answered.

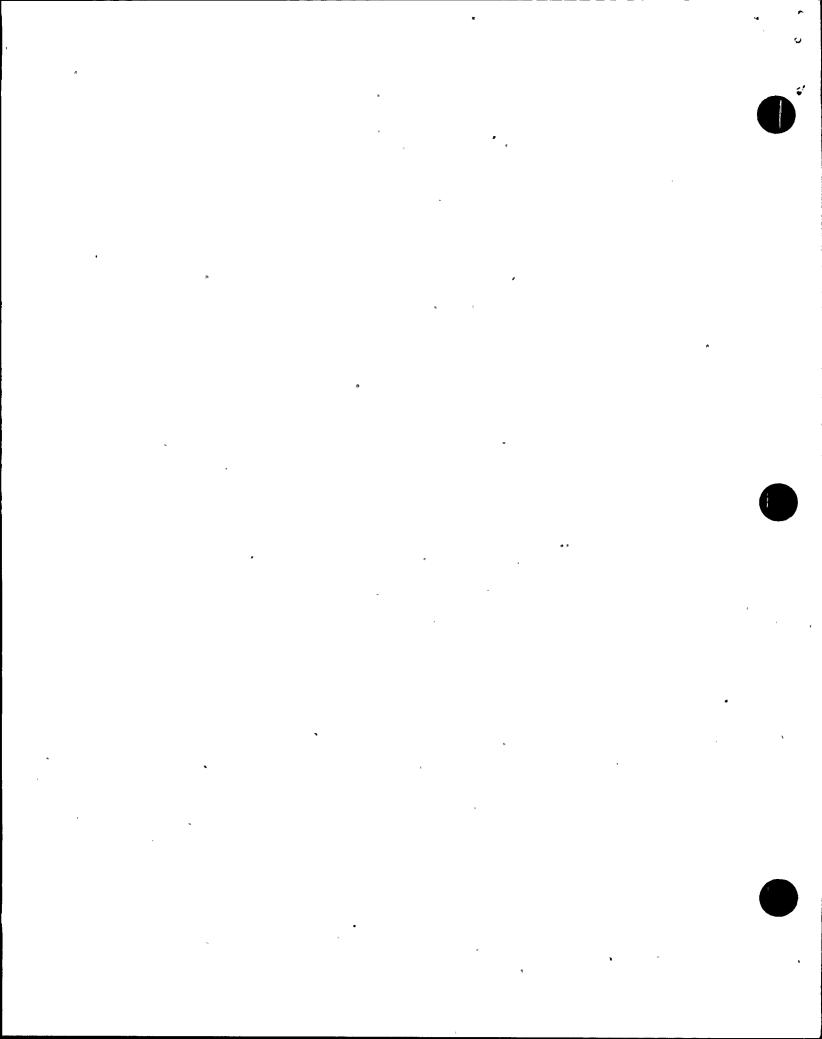
7. Drywell Equipment Hatch Inspections

Special inspections of the drywell equipment hatches on all 3 units were conducted in accordance with commitments made by TVA to the IE Region II Office. The commitments were included in the December 21, 1979 letter from the Acting Director of Region II to TVA.

The inspectors witnessed portions of these activities on December 20 and 21, 1979, which included visual inspections, corrective action being taken and performance of leak rate tests. Also records of the inspections and leak rate data were examined.

Although there was no significant leakage suspected, as confirmed by low nitrogen addition to the drywells, there were some deficiencies noted during the inspections by plant personnel. Misaligned lugs were noted on both equipment hatches of Unit 2; eight on the northwest hatch and six on the southeast hatch. On Unit 1 there were several lug nuts which were not fully torqued to 500 foot-pounds, but no leakage was evident. On Unit 3 there were no deficiencies identified. Corrective action on Unit 2 required exchanging lugs to their correct location and replacement of some of the 0-ring seals.

On December 21, 1979, one of the inspectors observed during a leak test of the Unit 2 southeast hatch that the test was being conducted using a version of the procedure which preceded the latest revision date (11/27/79). This test procedure is included in Surveillance Instruction 4.7.A.2.g-2, Primary Containment Testable Penetrations. Failure to use the latest approval revision of the test procedure was determined to be an apparent item of noncompliance (260/79-47-01) with Technical Specification 6.3.A which requires that detailed written procedures shall be prepared, approved and adhered to for safety-related activities. The licensee was informed of the inspectors finding on December 21, 1979.



Following completion of the inspections and necessary corrective actions the equipment hatches on all three units were again leak tested with satisfactory results.

Other inspection activities pertaining to the equipment hatches were contained in IE Inspection Report No. 50-259/79-45.

8. Plant Physical Protection

During the course of routine inspection activities, the inspectors made observations of certain plant physical protection activities. These included personnel badging, personnel search and escort, vehicle search and escort, communications and vital area access control. On December 19, 1979, a complete plant tour to specifically verify the condition of physical barriers was performed.

No items of noncompliance or deviations were identified within the areas inspected.